**Community Child Health Referral Form**

*NB: All referrals are triaged and children will be seen by the most appropriate professional – this may not be the person you have requested initially.*

**Childs Name: Date of Birth:**

**Address: NHS No:**

**Tel No’s: Home: Mobile:**

**Ethnicity:**

**Interpreter required Y/N (state which language)………..**

Name of Parents/Carer/Guardian (with parental responsibility):

Do you currently buy in our traded services (MCH+): Yes / No

If yes, and the referral is not accepted under NHS criteria, do you want the child to be seen under your traded contract? Yes / No

**Nursery/School:**

**Nursery/School address:**

**Nursery/School contact person:**

**Nursery/School/Tel no:**

**Does the child have an EHCP? Yes/no**

**How would you describe the child’s learning abilities?**

**GP Name and address:**

**Consultants:**

**Health Visitor/School Nurse:**

**Safeguarding Information**

**Child protection Plan: Y/N**

**Child in Need: Y/N**

**Known to Social Services disabilities team: Y/N**

**Looked After Child: Y/N**

**Any further info…………………………………………………………………………………..……**

**…………………………………………………………………………………………………………….**

**Named Social Worker:**

**Contact Details:**

**Visual Impairment: Y/N Hearing Impairment: Y/N**

**Other Services involved: …………………………………………………………..**

**Feeding and swallowing:**

Do you have any feeding or swallowing concerns? Yes / No

**If yes**, please complete; Weight: Height:

Date last weight / height taken:

Age when weaned: Current feeding method:

How long does it take for your child to eat a meal?

Have they had any chest infections? Yes / No

**If yes** how many in the last 6 months?

**Input requested (if known):**

**Additional relevant questionnaires/reports/assessments must be attached for the referral to be accepted.**

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| --- | --- | --- |
| **ADHD nurse led service (age 6-11 only – secondary pupils to be referred to NELFT – Emotional and Wellbeing service)** | **🞏** |  |
| **Community children’s nursing** | **🞏** |  |
| **Community nursing form** | **🞏** |  |
| **Continence service** | **🞏** |  |
| **Dietetics** | **🞏** |  |
| **Health Visiting** | **🞏** |  |
| **Joint Feeding Clinic (Dietetics/Speech and Language Therapy)** | **🞏** |  |
| **Learning disability nursing** | **🞏** |  |
| **Occupational Therapy – pre-school** | **🞏** |  |
| **Occupational Therapy – school aged (Physical Disability only on NHS)** | **🞏** |  |
| **Paediatrician** | **🞏** |  |
| **Parent education** | **🞏** |  |
| **Physiotherapy** | **🞏** |  |
| **Podiatry** | **🞏** |  |
| **School Nursing** | **🞏** |  |
| **Special school nursing** | **🞏** |  |
| **Speech & Language form** | **🞏** |  |
| **Speech and Language Therapy – pre-school** | **🞏** |  |
| **Speech and Language Therapy – school aged** | **🞏** |  |
| **Strengths and Difficulties questionnaires (parent and school –for correct age)** | **🞏** |  |

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| --- | --- |
| **What interventions have been tried and outcome:** | |
| **Intervention** | **Outcome** |
|  |  |
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| --- | --- |
| **Has Early Help been initiated?** | Yes/No |
| *If yes, please include minutes.* | |

**Reason for referral (**How does this affect their daily lives?**)**

**1.**

**2.**

**3.**

**4.**

**Are parents in agreement with this referral: Y/N (if no we will be unable to proceed with the referral)**

**Date of Referral: Referrer Name:**

**Contact Details:**

**Telephone No:**

**(Please email back completed form to Medch.childrenscommunity@nhs.net)**